MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08696

Reg. Diat. No. 23

1. PLACE OF DEATH:

County: A. A.

City or town: Glenburnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No. 210 Second Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Minnie M. Arnold

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 15 1874

8. AGE:

Years	Months	Days	If less than one day
73	0	19	..... hrs. ..... min.

9. Birthplace: A A Co Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Thomas H. Arnold

13. Birthplace: A A Co Md

MOTHER — 14. Maiden name: Eliza Waring

15. Birthplace: A A Co Md.

16. Informant: R. Harry Arnold

Address: Glenburnie A A Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 5 1947 (month) (day) (year)

Cemetery or crematory: Asbury

Location: Arnold Md

18. Funeral director: John M. Taylor Son

Address: Annapolis Md.

19. Oct 4 1947 (Date rec'd by registrar)

L. J. Dolle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 3 19 47 at 11 20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19 45 to Oct 3 19 47

and that I last saw h... alive on Oct 3 19 47

	DURATION
Immediate cause of death: Cerebral Hemorrhage	10 days
Due to: Cardio-Vascular Disease	2 yrs
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James J. Bielingolea M.D

M. D. or other

Address: Glen Burnie Md Date signed Oct 3 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

STATE OF MARYLAND—CERTIFICATE OF DEATH

61 08697

1. PLACE OF DEATH

County Anne Arundel. Registration Dist. No. 23

Village or City Glen Burnie No. 113 1st Av. S.W. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Wellington Whitmore Arnold If U. S. Veteran, specify WAR Yes WWI

(a) Residence: No. Same — St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male.	White	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lou. M. Arnold.

6. DATE OF BIRTH (month, day, and year) July 31, 1897

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	2	11	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Mechanic. (Retired)

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Navy Yard. Wash. D.C.

10. Date deceased last worked at this occupation (month and yaar) July. 1943

11. Totel time (years) spent in this occupation Not Esp.

12. BIRTHPLACE (city or town) (State or country) Frederick Co. Md.

FATHER

13. NAME Asbury Edward Arnold.

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Rose M. Hood.

16. BIRTHPLACE (city or town) (State or country) Frederick Co. Md

17. INFORMANT Mrs. W. W. Arnold. (Address) Glen Burnie. Md

18. BURIAL, ~~CREMATION,~~ OR REMOVAL Place Mt. Airy. Md Date Oct 13, 1947

19. UNDERTAKER C. M. Watty (Address) Mt Airy Md

20. FILED Oct 13, 1947 L. J. D'Alba Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Oct. (Month) 12 (Day), 1947 (Yaar)

22. I HEREBY CERTIFY, That I attendad deceasad from Jan. 1945, to Oct 12, 1947

I last saw him alive on Oct 11, 1947; death is said to have occurred on the date stated above, at 6. A. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importanca were as follows:

	Date of onset
Chronic Valvula Disease of the Heart	2 years
Othar **Contributory Causes** of importanca: Diabetis.	10 year

Name of operetion None Date of

What test confirmed diagnosis? Was there an autopsy?

23. If daath was dua to external ceuses (VIOLENCE) fill in also tha following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was diseasa or injury in any way relatad to occupation of deceasad? No

If so, specify

(Signed) Jama S. Billingsley M. D.

(Address) Glen Burnie Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

DT Johnson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

08699

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County Ann Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
56 Northwest

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Ann Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 56 Northwest
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
Albert Bias

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Ruth Bias

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 18, 1879

8. AGE: Years	Months	Days	If less than one day
68	5	13	..... hrs. ..... min.

9. Birthplace Annapolis
(Town, county, and state)

10. Usual occupation Building Attendant

11. Industry or business

FATHER
12. Name Frank Bias
13. Birthplace Md.

MOTHER
14. Maiden name Mary Ellen Watkins
15. Birthplace Md.

16. Informant Mrs. Mary Bias Bell
Address 56 Northwest St.

17. Burial Date thereof Nov. 5, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brewer Hill

Location Annapolis, Md.

18. Funeral director J.B. Johnson

Address Annapolis, Md P.O. Box 462

19. Nov. 5, 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1947, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 30, 1947, to Oct 31, 1947

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Apoplexy	2 days
Due to Hypertensive Cardio-Vascular Disease	
Due to	
Other conditions	6

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Theodore H. Johnson Jr.
M. D. or other

Address 40 Northwest St Annapolis, Md Date signed 11/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

08700

Reg. Dist. No. 28

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years, 8 months, 3 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 11 years, 8 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1119 Stockton Street
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME

LENA BOONE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: George Boone

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown to us Sept. 1881

8. AGE: Years	Months	Days	If less than one day
66	?	?	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: Moses Carter

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Laura Taylor

15. Birthplace: Virginia

18. Informant: Hospital Records

Address: Crownsville, Maryland

17. B. (Burial, cremation, or removal. Which?) Date thereof 11-3-47 (month) (day) (year)

Cemetery or crematory: Arbutus Arbutus Mem. Park

Location: Balto. Co.

18. Funeral director: Samuel W. Sullivan Jr

Address: 1011 N. Arlington Ave Balto.

19. Oct 31 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30th 19 47, at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 27th 19 36, to October 30th 19 47 and that I last saw h er alive on October 30th 19 47

	DURATION
Immediate cause of death: Cerebral Hemorrhage	one day
Due to: Malignant Hypertension	Known to us since 2/27/1936
Due to:	
Other conditions: Schizophrenia	Known to us since 2/27/1936

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ———— Date of:

Where did injury occur? ———— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D.
M. D. or other

Address: Crownsville, Maryland Date signed: 10/30/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d BC

08701

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years, 7 months, 21 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 4 years, 7 months, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1101 N. Stricker
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME
IDA BROWN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown 1887

8. AGE: Years	Months	Days	If less than one day
about 60			hrs. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Henry Jefferson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Marly Gross
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 11 47 (month) (day) (year)
Cemetery or crematory: Patuxent Chapel
Location: Calvert Co.
18. Funeral director: P. E. Burwell
Address: Prince Frederick, Md.
19. Oct. 9 19 47 E. T. Hope Rose (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October, 8th 19 47 at 6:00A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 17, 1943 to October 8th 19 47
and that I last saw her alive on October 8th 19 47

Immediate cause of death	DURATION
Hypertensive and Cardiovascular Disease	Known to us since 2/17/43
Due to:	
Due to:	
Other conditions: Psychosis with Arteriosclerotic Disease	Known to us since 2/17/43

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

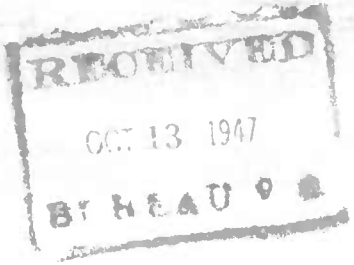
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jacob Hungerford M.D.
M. D. or other
Address: Date signed

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
OCT 13 1947
BY H&AU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08702

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
1309 West St Annapolis Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Maryland County: Anne Arundel
City or town: Sudley
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Clarence Owings Brundage

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): March 17 1887

8. AGE: Years	Months	Days	If less than one day
60	7	11	hrs. min.

9. Birthplace: New York State (Town, county, and state)
10. Usual occupation: Pile Driving
11. Industry or business
FATHER 12. Name: Nehemiah Brundage
13. Birthplace: ?
MOTHER 14. Maiden name: Lillie Owings
15. Birthplace: Shadyside Md
16. Informant: Anna Brundage
Address: Sudley Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 30 1947 (month) (day) (year)
Cemetery or crematory: Lyons Chapel
Location: Galesville Md
18. Funeral director: H. A. Gaudet & Son
Address: Galesville Md.
19. Oct 29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 28 1947, at 2 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 29 1943, to Oct 28 1947
and that I last saw him alive on Oct 27 1947

Immediate cause of death	DURATION
Coronary occlusion	
Due to arteriosclerosis	
Due to pleurisy?	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Brice H. Nelson, M.D. M. D. or other
Address: Lothian Md. Date signed 10/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

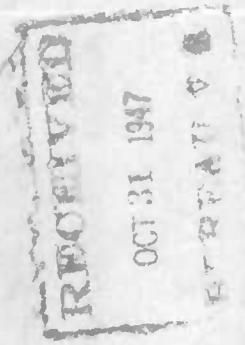
March 17 60

Cornwall-on-Hudson, N.Y.

1 day at Owings

1 A M Thurs. Oakland

1947
1886
61



Mrs Mey Hardesty
Allen Owings
~~Mary~~ Annapolis
Mrs Lem Atwell
Annapolis

Balt
wash
Capitol

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08703

932

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Parole Md. near Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 56 Years
Hospital, institution, or street address where death occurred:
Parole Md. near Annapolis
How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Parole Md. near Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Parole Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: Charles Carter

3.(b) Social Security Number: --None--

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mary Lane Carter
6.(c) If alive, give age: *** years

7. Birth date of deceased (mo., day, yr.): August 20, 1867

8. AGE: Years	Months	Days	If less than one day
80	1	19	...hrs. ...min.

9. Birthplace: Annapolis Md. (Town, county, and state)
10. Usual occupation: Government Employee
11. Industry or business: None
FATHER 12. Name: William Carter
FATHER 13. Birthplace: Unknown
MOTHER 14. Maiden name: Elizabeth Simms
MOTHER 15. Birthplace: Unknown
16. Informant: Mary Carter ~~Herndon~~ Herndon
Address: Parole Md. near Annapolis
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-12-47 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West Street Extended
18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street
19. Oct. 12 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9, 1947, 11:10AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 29, 1947, to October 9, 1947 and that I last saw him alive on October 9, 1947

Immediate cause of death: Cardiac Failure — DURATION

Due to: Hypertensive Cardio Vascular Disease.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. D. Johnson M. D.
Address: 40 Northwest Street M. D. or other
Date signed: 10/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


RECEIVED
OCT 16 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

830

0870407

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years, 2 months, 20 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 13 years, 2 months, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rock Point, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME: JAMES CHESLEY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: ———

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 65	?	?	..... hrs. ..... min.

9. Birthplace: Maryland (town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Frank Chesley
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lucy Lepen
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-13-47 (month) (day) (year)

Cemetery or crematory: Holy Ghost

Location: Crownsville Md

18. Funeral director: Hewitt & Ryon

Address: Hardesty Md

19. Oct 10 1947 (Date rec'd by registrar) E. K. Hayes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9th 1947 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 1941, to October 9th 1947 and that I last saw him alive on October 9th 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to: Cerebral Arteriosclerosis	Known to us for 6 years
Due to:	
Other conditions: Senile Psychosis	Known to us for 6 years

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of .....

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Jacob Thorpe M.D.
M. D. or other

Address: Crownsville, Maryland Date signed 10/9/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

09502

CERTIFICATE OF DEATH

RC Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 9 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 3 months, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland
County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1706 Redwood Street
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME JAMES CLAYTON

3. (b) Social Security Number

4. Sex: Male
5. Color or race: Negro
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age .... years
7. Birth date of deceased (mo., day, yr.) ?
8. AGE: Years 64 (64); Months ?; Days ?; If less than one day .... hrs. .... min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business
FATHER 12. Name: Samuel ?
13. Birthplace: Maryland
MOTHER 14. Maiden name: Sarah
15. Birthplace: Maryland
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Burial (Burial, cremation, or removal Which?) Date thereof 11/12-47 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md
18. Funeral director: Supt Hospital
Address: Crownsville Md
19. 11/12 1947 (Date rec'd by registrar) E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30th 1947, at 10:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21rst 1947, to October 30 1947
and that I last saw him alive on October 30th 1947

Immediate cause of death: Cerebral Arteriosclerosis — DURATION: Known to us since 7/21.47

Due to

Due to

Other conditions: General Arteriosclerosis — Known to us since 7/21/47
(Include pregnancy within 3 months of death)

Major findings of operations .... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury .... Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D. (M. D. or other)
Address: Crownsville, Maryland
Date signed: 10/30/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

08705

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 22 Maryland Ave., (Chase Home)
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Cecelia Cook Ditty

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	widow single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 7, 1853

8. AGE:

Years	Months	Days	If less than one day
94			hrs. min.

9. Birthplace: Davidsonville, A.A. Co. Md
(Town, county, and state)

10. Usual occupation: retired.

11. Industry or business:

FATHER
12. Name: Thomas Ditty
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Ann Hodges
15. Birthplace: Maryland.

16. Informant: Robert Ditty
Address: 1927 Cascade Ave., Baltimore Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Oct 9th 1947
(month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Glen Burnie
18. Funeral director: Wm. J. Tschudy & Son Co. Inc.
Address: W. North Ave. Baltimore Md

19. Oct 8, 1947
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 7, 1947 at 12-50 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~[illegible]~~
Postmortem Examination
~~[illegible]~~ Oct 7, 1947

Immediate cause of death	DURATION
Acute dilatation of Heart	sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md Date signed: 10-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

08706

Reg. Diat. No. 26

1. PLACE OF DEATH:

County A. A.

City or town Brooklyn (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 1/2 yr.

Hospital, Institution, or street address where death occurred: 5710 Magie St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County A. A.

City or town Brooklyn (If outside city or town limits, write RURAL and give nearest town)

Street No. 5710 Magie St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George Elsworth Dorsey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widow

B.(b) Name of husband or wife Violet Long.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 7- 1866

8. AGE: Years	Months	Days	If less than one day
81	3	23	..... hrs. ..... min.

9. Birthplace W. Va (Town, county, and state)

10. Usual occupation Carpenter.

11. Industry or business

FATHER 12. Name John Dorsey

13. Birthplace West Virginia

MOTHER 14. Maiden name Nancy Ingram

15. Birthplace West Virginia

16. Informant Mrs John Utz

Address 5704 Magie St

17. Burial (Burial, cremation, or removal? Which?) Date thereof 10/4/47 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Ritchie Highway

18. Funeral director John F. Denny, Inc

Address 715 Light St. -30

19. Oct 4 1947 (Date rec'd by registrar) A. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1 1947 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1945 to Oct. 1 1947 and that I last saw h... alive on Oct. 1 1947

Immediate cause of death	DURATION
Cardiac Vascular Disease	1 Day.
Due to	
Due to	
Other conditions Carbuncle Hemorrhage	2 yr.

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE Chas L. Ball Jr MD M. D. or other

Address Linthicum Date signed 10-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

08707

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: A. A. Co.

City or town: Annapolis Emergency Hospt.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2 Spa View Circle
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary A. Duckett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: Stephen W. Duckett

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 25th 1867

8. AGE:

Years	Months	Days	If less than one day
79	9	28	____ hrs. ____ min.

9. Birthplace: Prince George Co. Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: John P. Hopkins
13. Birthplace: Prince George Co. Md.

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Stephen W. Duckett
Address: 2 Spa View Circle Annap. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-24-47 (month) (day) (year)

Cemetery or crematory: Davidsonville M.E. Church

Location: Davidsonville Md.

18. Funeral director: John M. Taylor Sons

Address: Annapolis Maryland

19. Oct. 23 1947 (Date rec'd by registrar) ____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 22 1947, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 12 1947 to Oct 22 1947

and that I last saw h[illegible] alive on Oct 22 1947

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to: Coronary Disease	1 year
Due to:	
Other conditions: Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Geo. C. Boyd M. D. or other

Address: Annapolis Md Date signed 10-23-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08708

462

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Brooklyn Heights, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Brooklyn Heights, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 417 Audrey Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MARY M. EIDMAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: John M. Eidman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 23rd, 1870

8. AGE: Years	Months	Days	If less than one day
77	1	11	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER — 12. Name: Henry Greffen
13. Birthplace: Germany

MOTHER — 14. Maiden name: Sophia
15. Birthplace: Germany

16. Informant: Mrs. Howard H. Collison
Address: 417 Audrey Ave.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10/15/47 (month) (day) (year)

Cemetery or crematory: Western
Baltimore, Md.

Location:

18. Funeral director: Lasach Funeral Home
Address: 7401 Belair Rd.

19. Oct 14 1947 (Date rec'd by registrar) A. W. Hahnel Registrar

MEDICAL CERTIFICATION

a

20. DATE OF DEATH: Oct. 11th 1947 at 10:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 11 1947 to Oct. 11, 1947 and that I last saw her alive on Oct. 11, 1947

Immediate cause of death	DURATION
Carcinoma of Stomach(?)	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Ehrlich M. D. or other

Address: 5624 Queensberry Av Date signed: Oct. 11, 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932 08709

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: near Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Defense Highway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: near Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Defense Highway
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth White Eldridge

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Capt. Bayardus Eldridge

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feby. 6th 1852

8. AGE: Years	Months	Days	If less than one day
95	8	0	..... hrs. ..... min.

9. Birthplace: G. G. Co. Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Charles Hodges

13. Birthplace: A. A. Co. Md.

MOTHER 14. Maiden name: Ann M. Harwood

15. Birthplace: A. A. Co. Md.

16. Informant: Mrs. C. Addison Hodges

Address: Defense Highway - G. G. Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 9th '47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: James M. Hayes & Son

Address: Annapolis Md.

19. Oct 9, 47 (Date rec'd by registrar)

W. O. Dapuch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 7 1947 at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1943, to Oct 7 1947 and that I last saw h.r alive on Oct 6 1947

Immediate cause of death	DURATION
Senility	
Generalized arteriosclerosis	20 yrs.
Due to: & Arteriosclerotic heart disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: L. Bonsuch. M.D
M. D. or other

Address: Annapolis Md. Date signed: 10/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08710 1246

Reg. Dist. No. 22

1. PLACE OF DEATH:
County Anne Arundel
City or town Laurel (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Few hours
Hospital, institution, or street address where death occurred: Laurel Race Track
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State D.C. County
City or town Washington (If outside city or town limits, write RURAL and give nearest town)
Street No. 3541 - Eleventh St. N.W. (If rural, give LOCATION)
2.(a) If veteran, name war First World War

3. (a) FULL NAME ~~[struck out]~~ Alec Friedberg
3. (b) Social Security Number 577-24-4871

4. Sex M. | 5. Color or race W | 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Sarah Cohen
6.(c) If alive, give age 53 years
7. Birth date of deceased (mo., day, yr.) July 11 - 1893

8. AGE: Years 54 | Months 3 | Days 7 | If less than one day ... hrs. ... min.

9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual occupation Taxi Driver
11. Industry or business

FATHER
12. Name Morris A. Friedberg
13. Birthplace Russia

MOTHER
14. Maiden name ?
15. Birthplace ?

16. Informant Morris A. Friedberg
Address 3541 - Eleventh St. - N.W. - Washington D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 18, 1947 (month) (day) (year)
Cemetery or crematory
Location Washington, D.C.
18. Funeral director J. Arthur Walters
Address 505 Wash. Blvd., Laurel, Md.
19. Oct 18 1947 (Date rec'd by registrar) Clara Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1947, at 4.10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 — , to ... 19 ...
and that I last saw h— alive on ... 19 ...

	DURATION
Immediate cause of death Cerebral Hemorrhage	1 hr.
Due to Cirrhosis of the liver	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gustave H. Fraiebenbuk M.D. medical examiner
5. First Dist. A.A.Co.
Address Glen Burnie, Md. Date signed 10/18/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08711

2 08711

93d

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: A. A. Co.
City or town: Hanover Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Hanover
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Wm Gable

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 20. 1864

8. AGE: Years: 82 Months: 10 Days: 4 If less than one day: ..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Gable
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna D. Baker
15. Birthplace: Germany.

16. Informant: Dorothy Fifer
Address: Hanover Md.

17. Burial (Burial, cremation, or removal: Which?) Date thereof: Oct. 27. 47 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: 3801 Frederick Ave.

18. Funeral director: John O. Mitchell & Son
Address: ~~3804 Frederick Ave~~ 1820 Druid Park Place, Balto.

19. 26 Oct 1947 Gabriel Wentz Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 24 19 47, at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 21 19 47 to Oct. 24 19 47 and that I last saw h.. alive on Oct. 24 19 47

Immediate cause of death	DURATION
Cardio-Vascular Disease	3 days
Due to	
Due to	
Other conditions	
Cerebro vascular	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Chas. L. Bare M.D. M.D. or other
Address: Littlestown Date signed: 10-26-47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

William Gable

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

938

08712

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County A. A.

City or town Linthicum -
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yr.

Hospital, Institution, or street address where death occurred:
#505 Cleveland Rd.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A. A.

City or town Linthicum -
(If outside city or town limits, write RURAL and give nearest town)

Street No. 505 Cleveland Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME John Edward Gilbert

3. (b) Social Security Number 216-07-6102

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married.

B.(b) Name of husband or wife Grace Sheppard

6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) March 14 1892

8. AGE: Years	Months	Days	If less than one day
55	6	19	.....hrs. .....min.

9. Birthplace N. J.
(Town, county, and state)

10. Usual occupation Truck parts salesman

11. Industry or business (Ret.)

FATHER
12. Name Harry Gilbert -
13. Birthplace N. J.

MOTHER
14. Maiden name Catherine Willis
15. Birthplace N. Y.

16. Informant Mrs. John E. Gilbert
Address #505 Cleveland Rd, Linthicum Hghts

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 6, 1947 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location G.W. Ritchie Highway

18. Funeral director Thomas W. Singleton

Address Glen Burnie, Md

19. 10/6/47 19..... L. J. D'Alba Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1947 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 1947 to Oct. 3 1947 and that I last saw him alive on Oct. 3 - 1947

Immediate cause of death	DURATION
Cardio-Vascular Disease	5 yr.
Due to.....	.....
Due to.....	.....
Due to.....	.....
Other conditions	.....

(Incinde pregnancy within 3 months of death)

Major findings of operations .....

.....Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE Chas. L. Lee Jr. M.D.
M. D. or other

Address Linthicum - Date signed 10-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08713

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
21 College Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Ann Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 21 College Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary E. Gray

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: George W. Gray
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan., 26, 1884

8. AGE: Years	Months	Days	If less than one day
63	8	15	..... hrs. ..... min.

9. Birthplace: Calvert Co. Md.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: John Whittington
13. Birthplace: Md.

MOTHER
14. Maiden name: Haried Randall
15. Birthplace: Md.

16. Informant: Rev. Albert Gray
Address: 21 College Ave. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 14, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Zion
Location: Lothian, Md.

18. Funeral director: J.B. Johnson
Address: Annapolis, Md.

19. October 14 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11 1947, at 1 25 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11-20 1947, to 10-11-47 1947
and that I last saw her alive on 10-10-47 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. T. Talley M. D. or other
Address: 17 Carroll St Date signed 10-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

08714

Reg. Diat. No. 25

1. PLACE OF DEATH:

County A.A. County

City or town Brooklyn Hts

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A.A. County

City or town Brooklyn Hts -

(If outside city or town limits, write RURAL and give nearest town)

Street No. 212 Audrey Ave -

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah Elizabeth Green

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Jacob E. Green

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 14 1872

8. AGE: Years 75 | Months - | Days - | If less than one day ..... hrs. ..... min.

9. Birthplace Georgia (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John A. Stuart

13. Birthplace North Carolina

MOTHER 14. Maiden name Martha Evans

15. Birthplace North Carolina

16. Informant C.J. Carroll

Address 212 Audrey Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 1-47 (month) (day) (year)

Cemetery or crematory Hemptown Cemetery

Location Hemp. Georgia

18. Funeral director Milton Schilling

Address 3914 Hanover St Zone 25

19. October 28 1947 (Date rec'd by registrar) John M. Whetsell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27th 1947 at 1.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1947 to Oct 1947 and that I last saw h... alive on Oct 27 1947

Immediate cause of death	DURATION
coronary occlusion	
Due to hypertensive cardio vascular disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE P. W. Kuester MD (M. D. or other)

Address 302 Patapsco Ave Date signed Oct 27

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

830 08715 21

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Severn Md
(If outside city or town limits, write RURAL and name nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED.
(For newborn infant, give residence of mother)
State Md County Anne Arundel
City or town Severn
(If outside city or town limits, write RURAL and give nearest town)
Street No. Guinterfield Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Annie Hodges

3.(b) Social Security Number

4. Sex F | 5. Color or race B | 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Ernest Hodges

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11/4/1874

8. AGE: Years 72 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Southampton Co. Virginia
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden name Birdie Brown
15. Birthplace Va

16. Informant Clara Foster
Address Severn, Md

17. Burial Date thereof 10/31/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Franklin, Va.
Location Franklin, Va.

18. Funeral director Wm. G. Nelson
Address 1303 Pressman St

19. Oct 30 1947 A. D. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 28 1947 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 10 1947 to Oct 28 1947
and that I last saw alive on Oct 24 1947

Immediate cause of death: Cerebral Hemorrhage — DURATION: 4 days

Due to:

Due to:

Other conditions: Cerebral Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. W. Lockey M. D. or other
Address Edgewood Md Date Oct 28-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

105

08716 22

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Annie Arundel

City or town: Jessups, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? nine days

Hospital, Institution, or street address where death occurred:
nine

How long in hospital or institution? nine

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A.A.

City or town: Jessups
(If outside city or town limits, write RURAL and give nearest town)

Street No. - - -
(If rural, give LOCATION)

2.(a) If veteran, name war: ??

3.(a) FULL NAME: William Hodges

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col'd	Married

6.(b) Name of husband or wife: Mary B. Hodges

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
67			....hrs. ....min.

9. Birthplace: (Town, county, and state)

10. Usual occupation: Not known

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace: "

MOTHER 14. Maiden name: Unknown

15. Birthplace: "

16. Informant: Maryland House of Correction,

Address: Jessups, Maryland,

17. (Burial, cremation, or removal) Which? Burial Date thereof (month) (day) (year) Nov 7-47

Cemetery or crematory: Cherry Tree

Location: Jessup Md

18. Funeral director: W. L. Collins

Address: Jessup Md

19. (Date rec'd by registrar) Nov 6 1947 Registrar: Clara Haslup

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 25, 1947 at 8:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 18 1947 to Oct. 25, 1947 and that I last saw him alive on Oct. 25, 1947

Immediate cause of death	DURATION
Exhaustion	5 days
Due to: Pneumonia, lobar, both lungs	9 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John A Clark M.D.
M.D. or other

Address: Jessups, Md. Date signed: 10-26-47.

Dr. Richardson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08717

CERTIFICATE OF DEATH 50

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Ann Arundel
City or town Annapolis,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
I39 West Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Ann Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. I39 West Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Martha Thomas Holland

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife Joshua Holland
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, I895

8. AGE: Years	Months	Days	If less than one day
52	4	I0	hrs. min.

9. Birthplace Annapolis, A.A.Co. Md.
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business

FATHER
12. Name Isaac Thomas
13. Birthplace Md.

MOTHER
14. Maiden name Henretta Johnson
15. Birthplace Md.

16. Informant Catherine Johnson
Address I39 West St. Annapolis, Md.
17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Oct. I9, I947
(month) (day) (year)
Cemetery or crematory Brewer Hill
Location Annapolis, Md.
18. Funeral director J.B.Johnson
Address Annapolis, Md.
19. Oct. 19, 19 47
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 19 47 at 12:03 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 19 47 to October 16 19 47 and that I last saw her alive on October 19 47

Immediate cause of death	DURATION
Carcinoma of Breast	I0 months
Due to	
Due to	
Other conditions Acute Pleurisy	3 months

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. L. Richardson M.D.
M. D. or other
Address Annapolis, Md. Date signed 10/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

08718

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:
County Anne Arundel
City or town P.O. Severna Park.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred:
Robinson station.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State [illegible] County
City or town [illegible]
(If outside city or town limits, write RURAL and give nearest town)
Street No. 224
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mr. Harry Lesley Happel

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	married.

6.(b) Name of husband or wife Annie L. Crouse
6.(c) If alive, give age 83 years
7. Birth date of deceased (mo., day, yr.) June 28 - 1864

8. AGE: Years	Months	Days	If less than one day
83	3	21	...hrs. ...min.

9. Birthplace Hagerstown, Md.
(Town, county, and state)
10. Usual occupation Molder.
11. Industry or business Iron

FATHER
12. Name George Happel
13. Birthplace Germany, Europe.

MOTHER
14. Maiden name Maretta Walsappel
15. Birthplace Germany, Md.

16. Informant Mrs. Annie L. Happel (wife).
Address Robinson station, P.O. Severna Park, Md.

17. Burial Date thereof 10/21/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Burns Hill
Location Waynesboro Pa.

18. Funeral director William Cook Inc
Address 1217 St. Paul St

19. 10-20 1947 W. A. Andrews
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1947 at 1.50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947 to October 1947 and that I last saw h. [illegible] alive on ... 19...

Immediate cause of death	DURATION
General asteni - exhaustion	7
Due to Senility -	
Due to General debility -	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gustave H. Faucher M.D.
M. D. or other
Address Glen Burnie, Md. Date signed 10/19/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF MARYLAND—CERTIFICATE OF DEATH

08719

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 2

Village or City Severna Park No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Clara C. Johnson If U. S. Veteran, specify WAR

(a) Residence: No. Severna Park St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	W

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of S.F.Johnson

6. DATE OF BIRTH (month, day, and year) 4/28/1864

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83	5	20	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Hagerstown, Md. (State or country)

FATHER

13. NAME George Reed

14. BIRTHPLACE (city or town) Md. (State or country)

MOTHER

15. MAIDEN NAME Sarah Crawford

16. BIRTHPLACE (city or town) Md. (State or country)

17. INFORMANT Family (Address) Severna Park

18. BURIAL, CREMATION, OR REMOVAL Place Rose Hill Date 10/20 19 47

19. UNDERTAKER James L. McCauley (Address) 130 E. Fort Ave.

20. FILED Oct 20, 19 47 A. W. Hedrick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Oct 18. (Month) (Day), 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan., 1941, to Oct 18, 1947

I last saw her alive on Oct 17, 1947; death is said to have occurred on the date stated above, at m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage.	2 wks.
Dthar Contributory Causes of Importance: Cardio-Vascular Disease	4 years

Name of operation No Date of —

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did Injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Jane S. Buckingham M. D.

(Address) Glen Burnie, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

137a 08720

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 Years
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 20 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 77 Washington Street
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: John Henry Johnson J

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Sarah Johnson
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 29 1877

8. AGE: Years	Months	Days	If less than one day
70	4	27	..... hrs. ..... min.

9. Birthplace: Rutland A. A. Co. Md.
(Town, county, and state)
10. Usual occupation: Minister
11. Industry or business: None
FATHER 12. Name: John Henry Johnson
13. Birthplace: Rutland A. A. Co. Md.
MOTHER 14. Maiden name: Louise Harris
15. Birthplace: Rutland A. A. Co. Md.
16. Informant: Louis Mathews
Address: 77 Washington Street
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10- 21-1947 (month) (day) (year)
Cemetery or crematory: Mt. Tabor Cemetery
Location: Mt. Tabor Anne Arundel Co. Md.
18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street
19. Oct. 21 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17, 1947 19 2:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 27 1947 to Oct 17 1947 and that I last saw h... alive on Oct 17 1947

Immediate cause of death	DURATION
Uremic Coma	3 days
Due to Prostatectomy (Benign) Hypertension	3 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Benign Prostatectomy Hypertension Date of op. 10/13/47

Autopsy result:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Albert L. Anderson MD M. D. or other
Address: Annapolis, Md. Date signed: 10/21/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct ... is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

08721

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM JOHNSON

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: Negro

6.(a) Single, married, widowed, or divorced: ?

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.):

8. AGE: Years: about 73 Months: ? Days: ? If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER
12. Name: John Johnson
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Margaret
15. Birthplace: West Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/31/1947 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md

18. Funeral director: Supt. Hospital
Address: Crownsville Md

19. 10/31 1947 (Date rec'd by registrar) E. F. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24th 1947 at 6:05 A. M

21. I attended the deceased from October 16th 1947 to October 24th 1947
I saw her/him on October 24th 1947
and last saw her/him alive on 1947
Immediate cause of death: Cerebral Arteriosclerosis — DURATION: Known to us since October 16, 1947

Due to:

Due to:

Other conditions: Psychosis With Cerebral Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jacob Lawrence M. D.
M. D. or other
Address: Crownsville, Maryland Date signed: 10/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr. Richardson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08722

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Rear) 110 Clay Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: AnnArundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rear) 110 Clay Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sarah Jones

3.(b) Social Security Number

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: John Jones
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 27, 1906

8. AGE: Years: 41 Months: 6 Days: 24 If less than one day: hrs. min.

9. Birthplace: Skidmore, Md. A.A.Co.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: Cornelius Smith
13. Birthplace: Md.

MOTHER
14. Maiden name: Daisy Simms
15. Birthplace: Md.

16. Informant: Estelle Allsupe
Address: Annapolis Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof October 23, 1947
(month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetery
Location: Annapolis, Md.

18. Funeral director: J.B.Johnson
Address: Annapolis, Md.

19. Oct. 22 1947
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 19, 1947, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15 1947 to October 19, 1947
and that I last saw h[illegible] alive on October 19, 1947

Immediate cause of death: Lobar Pneumonia — DURATION: 6 Days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. P. Richardson M D
M. D. or other
Address: 110 Clay St. Annapolis Md. Date signed: 10/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 — 08723 — 28

Reg. Dist. No.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years, 2 months, 1 day
Hospital, Institution, or street address where death occurred:
Crownsville State Hopital, Crownsville, Md.
How long in hospital or institution? 7 years, 2 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: House of Good Sheppard
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MARY KELLY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown to us

8. AGE: Years	Months	Days	If less than one day
53	?	?	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laundry Work

11. Industry or business:

FATHER
12. Name: Samuel Kelly
13. Birthplace: aryland

MOTHER
14. Maiden name: Mary(unknown)
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/31/47 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md
18. Funeral director: Asst Hospital
Address: Crownsville Md

19. 10/31/47 (Date rec'd by registrar) 19 E. Hoyle Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27th 19 47 at 6:05 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 26th 19 40 to October 27th 19 47 and that I last saw her alive on October 27th 19 47

Immediate cause of death	DURATION
Cerebral Arteriosclerosis known to us since Aug. 26, 1940	
Due to	
Due to	
Other conditions: Psychosis With Cerebral Arteriosclerosis Known to us since Aug. 26, 1940 (Include pregnancy within 3 months of death)	

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jacob Mayerstein M.D. M. D. or other
Address: Crownsville, Maryland Date signed 10/27/47

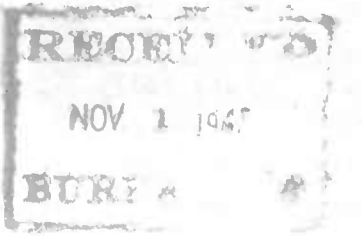
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

6937

Kelly - Mary
Admitted August 26, 1940
Died October 27, 1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08724

932

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 203 Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Irma M. Klein

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Divorced

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 4th 1896

8. AGE: Years	Months	Days	If less than one day
51	1	5	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Credit Mgr. Annapolis Utilities Co.
11. Industry or business

FATHER
12. Name: Joseph H. McCoy
13. Birthplace: Bernerville, N. J.

MOTHER
14. Maiden name: Jennie Harper
15. Birthplace: Boonetown, N. J.

16. Informant: Mary Alice Klein
Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 11th '47 (month) (day) (year)
Cemetery or crematory: Woodlawn Cemetery
Location: Baltimore, Md.

18. Funeral director: John W. Taylor Son
Address: Annapolis Md.

19. Oct. 10 1947 (Date rec'd by registrar) W. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 9 1947 at 2:10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1942 to Oct 9 1947 and that I last saw h-er alive on Oct 9 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	4½ hrs
Due to Arteriosclerotic cardio-vascular renal disease &	
Due to Hypertension is	7 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

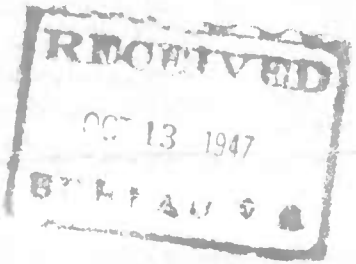
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: S. Bornstein M.D. M. D. or other
Address: Annapolis Md Date signed 10/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M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OCT 13 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a ex 08725 21

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Neck

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks.

Hospital, institution, or street address where death occurred: Emergency Hospital - Annapolis

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5000 Catalpha Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Minnie A. Korb

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Gustavus A. Korb

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Feb 3, 1876

8. AGE: Years: 71 | Months: 8 | Days: 6 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business:

FATHER 12. Name: George Pettit

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Caroline [illegible] Huber

MOTHER 15. Birthplace: Germany

16. Informant: Gustavus A. Korb

Address: 5000 Catalpha Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 13. 1947 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: 3801 Frederick Ave

18. Funeral director: Jos. Jos. John H. Feifel & Son

Address: 5311 Edmondson Ave.

19. 10/10 19 47 A. W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9, 1947 at 9:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 8 1947, to Oct 9 1947

and that I last saw h[illegible] alive on Oct 9, 1947

Immediate cause of death	DURATION
Coronary Thrombosis	Minutes
Due to	
Due to	
Other conditions: Chronic Dilatation of the Heart	14 days

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Albert L. Anderson M.D. M. D. or other

Address: Annapolis, Md. Date signed: 10/9/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932 08726

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Arnold Station Anne Arundel County

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Anne Arundel

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No.: R. F. D. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Martha E. Krecz

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widowed

6.(b) Name of husband or wife: Martin A.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1887

8. AGE: Years	Months	Days	If less than one day
60			hrs. min.

9. Birthplace: Lith (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

MOTHER FATHER

12. Name: George ?

13. Birthplace: Lith ?

MOTHER

14. Maiden name:

15. Birthplace: Lyth

16. Informant: Mary Krecz Smith

Address: 3 Glendale Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 24-47 (month) (day) (year)

Cemetery or crematory: Holy Redeemer Cem.

Location: Baltic Rd

18. Funeral director: Joseph Kasmikas Inc

Address: 6 E Washington Balt

19. 10-20 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 19 1947 at 11:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 17 1947 to Oct. 19 1947 and that I last saw h[er] alive on Oct. 19 1947

Immediate cause of death	DURATION
myocardial failure	1 day
Due to arteriosclerotic cardio-vascular disease &	1-2 yrs.(?)
Due to hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. Bozzuto M.D M. D. or other

Address: Annapolis Md Date signed: 10/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08727

94a

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, Institution, or street address where death occurred: 17 Cornhill St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No. 17 Cornhill St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: WILLIAM E. LAMB

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: White

8.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Carrie E. Lamb

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 13, 1870

8. AGE: Years: 77 Months: 7 Days: 19 If less than one day: hrs. min.

9. Birthplace: Annapolis, Maryland (Town, county, and state)

10. Usual occupation: Retired Fireman

11. Industry or business

FATHER

12. Name: Henry Lamb

13. Birthplace: Maryland

MOTHER

14. Maiden name: Rose McNew

15. Birthplace: Maryland

16. Informant: RICHARD OLIVER LAMB. Cedar Bluff Cemetery

Address: 17 CORNHILL ST, ANNAPOLIS, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 5, 1947 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Maryland

19. Oct. 3 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 2 1947 at 11 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 30 1947 to Oct 2 1947 and that I last saw h... alive on Oct. 2 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	2 days
Due to:	
Due to:	
Other conditions: Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George C Boyle M. D. or other

Address: Annapolis Md Date signed: 10-3-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

08728

Reg. Dist. No. 21

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The (I) age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Anne Arundel
City or town Emergency Hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Galesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Hattie May Leatherbury

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Harvey E. Leatherbury
6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) March 25, 1873

8. AGE: Years 74 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Tracys a. Md.
(Town, county, and state)

10. Usual occupation Home wife

11. Industry or business

FATHER
12. Name William Dixon
13. Birthplace Md

MOTHER
14. Maiden name Sophie Nutwell
15. Birthplace Md.

16. Informant altoe Leatherbury
Address Galesville Md

17. Burial Date thereof Oct 9 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Quaker Cemetery
Location Galesville Md
18. Funeral director W. G. Standesty + Son
Address Galesville Md.

19. Oct. 9 1947 W. O. Council Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1947, at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1942 to Oct. 8 1947 and that I last saw h... alive on Oct. 8 1947

	DURATION
Immediate cause of death Myocardial failure	8 hrs
Due to Arteriosclerosis	
Due to Hypertension	10 yrs.
Other conditions Diabetes mellitus	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE S. Bosworth M.D.
M. D. or other
Address Annapolis Md Date signed Oct 9 1947

11.40

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08729

932

21

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: A. A. Co

City or town: Annapolis, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 505 Burnside Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Mrs Anna Bertha Annie Lohcefer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	white	widowed

6.(b) Name of husband or wife: xx August Lohcefer - deceased

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 25, 1892

8. AGE: Years	Months	Days	If less than one day
55			hrs. min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Frank Howard Broaders, Sr.

FATHER 13. Birthplace: Baltimcre, Md

MOTHER 14. Maiden name: Mary Gouker

MOTHER 15. Birthplace: Pennsylvania

16. Informant: Carl Lohcefer - son

Address: 4015 Bellwood Ave., Balto- 6 - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/29/47 (month) (day) (year)

Cemetery or crematory: xxx Oak Hill Cemetery

Location: Horner's Lane, Baltimore, Md

18. Funeral director: Charles E. Schimunek

Address: 2601-3-5 E. Madison Street

19. Oct 29 1947 (Date rec'd by registrar) A. W. Holland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 25 1947, at 9:22 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 18 1947, to Oct. 25 1947 and that I last saw h=R alive on Oct. 25 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Hypertension Chronic	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Eastport Date signed: 10/31/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08730

94a

Reg. Diat. No. 21

1. PLACE OF DEATH.

County Anne Arundel

City or town Severn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For non-born infants give residence of mother)

State Md. County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1130 S. Charles St.

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME William H. Madkins

3.(b) Social Security Number 220-22-7669

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Esta Madkins

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 14, 1875

8. AGE: Years 72 | Months 7 | Days 17 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Eastern Shore Md.

(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Produce business

FATHER — 12. Name: Frank Madkins

FATHER — 13. Birthplace:

MOTHER — 14. Maiden name: Rebecca

MOTHER — 15. Birthplace:

16. Informant: Esta Madkins

Address: 1130 S. Charles St.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof Oct. 4 1947 (month) (day) (year)

Cemetery or crematory: CEDAR HILL

Location: A. A. Co. MARYLAND

16. Funeral director: Wm. Cook Inc.

Address: 1217 St. Paul St.

19. Oct 2 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1/47 19 ..... at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/1/47 19 ..... to ..... 19 .....

and that I last saw h.. alive on 10/1/47 19 .....

	DURATION
Immediate cause of death: Coronary Occlusion	
Due to:	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John J. Alexander M. D. or other

Address Glen Burnie Date signed 10/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08731

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Woodlawn Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A A Co.
City or town: Woodlawn Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 112 FORRESTDALE AVE
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Katherine Mahrenholz.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEM	WHITE	WIDOW

6.(b) Name of husband or wife: CONRAD MAHRENHOLZ
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): APRIL 15 - 1880

8. AGE: Years	Months	Days	If less than one day
67	5	20	..... hrs. ..... min.

9. Birthplace: BALTIMORE MD (Town, county, and state)
10. Usual occupation: HOUSE WORK.
11. Industry or business: AT HOME.

FATHER
12. Name: ANTHONY. CREAMER
13. Birthplace: BALTIMORE MD

MOTHER
14. Maiden name: MARGT. SCHECKELS
15. Birthplace: BALTIMORE MD.

16. Informant: MR LEO MAHRENHOLZ.
Address: 3308 ANNAPOLIS AVE

17. BURIAL. (Burial, cremation, or removal. Which?) Date thereof: OCT 9-47 (month) (day) (year)
Cemetery or crematory: HOLY CROSS CEM.
Location: A. A. Co.

18. Funeral director: BERNARD C. HARLE.
Address: 121 E WEST ST.

19. 10/6 19 47 A. W. Hedrick Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 5th 19 47 at 9 45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 14 19 44 to Octo 5th 19 47
and that I last saw h alive on 10/3/47 19

Immediate cause of death	DURATION
Coronary Occlusion	3 hrs.
Due to Hypertension	3 years
Due to Arterio-sclerosis	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: NO Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Gustave A. Rauchenbach M.D. M. D. or other
Address: Glen Burnie Md Date signed: 10/6/47

Please write clearly and legibly. Physicians: please write the causes of death clearly and legibly.

STATE OF MARYLAND—CERTIFICATE OF DEATH

93d

08732

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 23

Village or City Near Furnace Branch — No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Annie Martin — If U. S. Veteran, specify WAR No

(a) Residence: No. Box 135 - Brooklyn 25 - R7 D. 9 St., Md Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	Colored.	Widowed.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wellesin Dawes

6. DATE OF BIRTH (month, dey, and year) Aug 2 - 1880

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	29	

OCCUPATION

8. Trede, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. At home.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. At home.

10. Date deceased last worked et this occupetion (month and year) 1946

11. Total time (years) spent in this occupation All her life.

12. BIRTHPLACE (city or town) A. A. Co. Md.
(Stete or country)

FATHER

13. NAME Unknown.

14. BIRTHPLACE (city or town) Unknown
(State or country)

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) Unknown.
(State or country)

17. INFORMANT Thos. Wellesin
(Address) Brooklyn 25 R 7 D

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Calvery Cem. Date Nov. 4, 1947

19. UNDERTAKER Elroy O. Wilson
(Address) 1000 Brantly ave

20. FILED Nov 4, 1947 A. W. Hedricle
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Oct. (Month) 31 (Day) 1947 (Yeer)

22. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1947, to Oct 31, 1947

I last saw h-- alive on Oct 29, 1947; death is seid to heve occurred on the date stated above, at 6 P. m.

The **PRINCIPAL CAUSE OF DEATH** and related ceuses of importance were as follows:

	Date of onset
Cardio - Vascular Disease	2 years

Other **Contributory Causes** of importance:

Name of operation None Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to externel causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Dete of Injury 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Neture of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify James S. Bellenger.

(Signed) Ellen Burns M. D.

(Address) Md.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at **school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own **home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other **contributory causes of importance:**	
Gallstones	*May 1, 1923*

Example II

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other **contributory causes of importance:**	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08733

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Ann Arundel
City or town Parole, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Ann Arundel
City or town Parole
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Marcellous Matthews

3.(b) Social Security Number

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Gazelle Matthews
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) May 8, 1888
8. AGE: Years 59 Months 5 Days 19 If less than one day ..... hrs. ..... min.
9. Birthplace Shadyside, A.A.Co. Md. (Town, county, and state)
10. Usual occupation Waterman
11. Industry or business

FATHER
12. Name Joseph Matthews
13. Birthplace Md.

MOTHER
14. Maiden name Mary E. Holland
15. Birthplace Md.

16. Informant Lorraine Green
Address Parole, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 26, 1947 (month) (day) (year)
Cemetery or crematory St. Matthews
Location Shadyside, Md.
18. Funeral director J.B. Johnson
Address Annapolis, Md.

19. Oct. 26 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23, 1947, at 8:55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18 1947 to October 23 1947 and that I last saw h[illegible] alive on October 23, 1947

Immediate cause of death	DURATION
Lobar Pneumonia	6 days
Due to Influenza	3 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE R.E. Richardson M.D. M. D. or other
Address 110 - Clay St. Annapolis Md. Date signed 10/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08734

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: A. A. Co.
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: A. A. Co.
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
Street No.: Defense Highway (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Katie A. Miller
3. (b) Social Security Number:

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Harry W. Miller
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): October 9th 1877

8. AGE: Years: 70 Months: 0 Days: 2 If less than one day ... hrs. ... min.

9. Birthplace: A. A. Co. Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Arnold H. Miller
Address: Defence Highway A. A. Co. Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Oct 14th 1947 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.

18. Funeral director: John M. Taylor Son
Address: Annapolis, Maryland

19. Oct. 14 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 11 1947, at 11 40 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended the deceased from~~ Postmortem Examination
~~and that I last saw h... alive on~~ 19

Immediate cause of death	DURATION
Acute Dilatation of Heart	Sudden
Due to: Chronic Myocarditis	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: John N. Coffey M.D. Deputy Medical Examiner M. D. or other
Address: Annapolis, Md. Date signed: 10/13/47

08735

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 63 days
Hospital, institution, or street address where death occurred:
U.S.Naval Hospital, Annapolis, Maryland
How long in hospital or institution? 63 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4 German Street
(If rural, give LOCATION)
2.(a) If veteran, name war: World War One

3.(a) FULL NAME: MORGAN, Raymond Charles

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Wife: Mrs. Florence A. MORGAN
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): October 29, 1893

8. AGE: Years	Months	Days	If less than one day
54	00	2	...hrs. ...min.

8. Birthplace: A nnapolis, Maryland (Town, county, and state)
10. Usual occupation: USN-Inactive-Retired
11. Industry or business: USN-Inactive-Retired

FATHER
12. Name: Samuel Morgan
13. Birthplace: Annapolis, Maryland

MOTHER
14. Maiden name: Alberta Hasslip
15. Birthplace: Annapolis, Maryland

16. Informant: Mrs. Florence A. MORGAN (wife)
Address: 4 German St., Annapolis, Maryland

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof Nov 3 1947 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis, Md.
18. Funeral director: John M. Taylor Son
Address: Annapolis Md.

19. Nov. 2, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 31 October 1947, at 1:56 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28 1947, to 31 October 1947 and that I last saw him alive on 31 October 1947

Immediate cause of death	DURATION
Pulmonary Edema	
Due to: Carcinoma, Left Lung	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Verification of above Date of op. 31 Oct. 1947
Autopsy results: Verification of above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: USN Hospital Date signed 11-1-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940a

087362

CERTIFICATE OF DEATH

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Anne Arundel

City or town: Odenton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 56 years

Hospital, Institution, or street address where death occurred: Odenton md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: A.A.

City or town: Odenton
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Antoinette J. Muirhead

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife: S. Scott Muirhead

1867 - 4 - 11 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 2, 1861

8. AGE:

Years	Months	Days	If less than one day
86	1	9	hrs. min.

9. Birthplace: Odenton Anne Arundel Co. Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Noah Waters Annearundel

13. Birthplace: anne arundel Co. Md

MOTHER 14. Maiden name: M. Antoinette Sparrs

15. Birthplace: Frederick Co Md

16. Informant: Ruth Muirhead Watts

Address: Odenton Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof 10 - 14 - 1947 (month) (day) (year)

Cemetery or crematory: Epiphany

Location: Odenton Md

18. Funeral director: Beth H. Worthington

Address: Laurel Md.

19. Oct 14 1947 (Date rec'd by registrar) Clara Laslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 11 19 47 at 6.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February, 19 46 to Oct-10 19 47 and that I last saw h... alive on Oct-11 19 47

Immediate cause of death: Coronary thrus

DURATION: 4 days

Due to: Hypertension Arterio Sclerosis 7 Mos

Due to:

Other conditions: Fracture of hip - due to fall 17 mos. prior to death.
(Include pregnancy within 3 months of death) 11/25/47 - O.S.

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Osborn Newnam M. D. or other

Address: Millersville Md Date signed: 10-14-47


NOV 7 1917
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 08737

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 mos. 13 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 10 mos. 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 613 N. Calhoun St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Kato Murray

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife: ------

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 5, 1905.

8. AGE: Years	Months	Days	If less than one day
42	7	10	____ hrs. ____ min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business

FATHER
12. Name: Edward Murray
13. Birthplace: NORTH CAROLINA

MOTHER
14. Maiden name: Minnie Greene
15. Birthplace: North Carolina

16. Informant: Hospital Records

Address: Crownsville Maryland

17. (Burial, cremation, or removal. Which?) Date thereof: 10 15 47 (month) (day) (year)

Cemetery or crematory: Friendly Town

Location: N.C.

18. Funeral director: Katie R. Williams

Address: 3222 N. Schroeder St.

19. (Date rec'd by registrar) Oct 14 19 47 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 13, 1947 19 47, at 10:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15, 1946 19 46, to Oct. 13 19 47 and that I last saw him alive on Oct. 13, 1947 19 47

	DURATION
Immediate cause of death: Lung Tuberculosis	9/26/47
Due to:	
Due to:	
Other conditions: Schizophrenia Paranoid Type	11/15/46

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Jacob Mayer Gutentag M.D.
M. D. or other

Address: ____ Date signed: ____

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

pc 08738

Reg. Dist. No. 2-8

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 9 months. 17 da.

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 3yrs. 9 mo. 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: -----

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 324 E. 23rd. St.
(If rural, give LOCATION)

2.(a) If veteran, name war: /

3.(a) FULL NAME: PETER NIXON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: ------

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 2/2/1922

8. AGE: Years	Months	Days	If less than one day
25	-8	15	____ hrs. ____ min.

9. Birthplace: Arkansas
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER
12. Name: Albert Nixon
13. Birthplace: Arkansas

MOTHER
14. Maiden name: Mary Clay
15. Birthplace: South Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. B. (Burial, cremation, or removal, Which?) Date thereof 10-25-47 (month) (day) (year)

Cemetery or crematory: ~~Loudon Park~~ Mt. Auburn

Location: ~~Old Bay~~ Balto. City

18. Funeral director: Samuel W. Sullivan Jr.

Address: 1011 N. Arlington Ave. Balto.

19. Oct. 20 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17 1947, at 10:30a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 7 1944, to October 17 1947 and that I last saw him alive on Oct. 17, 1947

	DURATION
Immediate cause of death: Tuberculosis of the lung.	2/15/47
Due to:	
Due to:	
Other conditions: Dementia Praecox	2/7/44

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Jacob Hungerford M.D.
M. D. or other

Address: ____ Date signed: ____

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

#8600

Peter Nixon
Admitted Feb. 7, 1944
Died October 17, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

08739

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 13 Obrine Court
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Dansbury Queen

3.(b) Social Security Number: 214-05-2954

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mary Queen
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 8, 1882

8. AGE: Years	Months	Days	If less than one day
65	1	1	hrs. min.

9. Birthplace: Annapolis Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: None

FATHER
12. Name: Thomas Queen
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Annie Snowden
Address: 14 Obrine Court

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-14-1947 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West Street Extended

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. Oct. 14 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9, 1947, at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 11, 1947 to Oct 9, 1947 and that I last saw h... alive on October 9, 1947

	DURATION
Immediate cause of death: Gangrene of the left foot & leg	3 months
Due to:	
Due to:	
Other conditions: Diabetes Mellitus	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Diabetes Gangrene left foot & leg Date of op. Sept 19, 1947
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gilbert L. Anderson M.D. M. D. or other
Address: Annapolis, Md. Date signed: 10/14/47


RECEIVED
OCT 16 1947
BUR. A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08740

167

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All his life, 40 yrs.
Hospital, institution, or street address where death occurred:
14 Monument St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9 Monument St
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Shelton Winfred Randall

3.(b) Social Security Number: 214-05-1241

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	married

6.(b) Name of husband or wife: Sarah Virginia Randall
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): August 5, 1907

8. AGE:

Years	Months	Days	If less than one day
40	2	20	...hrs. ...min.

9. Birthplace: Annapolis A.A. Co Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: none

FATHER
12. Name: Louis Randall
13. Birthplace: A.A. South River

MOTHER
14. Maiden name: Elizabeth Simpson
15. Birthplace: Skidmore Md.

16. Informant: Mrs Sarah V. Randall
Address: 9 Monument St Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/29/47 (month) (day) (year)
Cemetery or crematory: Bywy Hill Cemetery
Location: West St. Extd.

18. Funeral director: Mrs Charles B. Hicks
Address: 45 Northwest St Annapolis Md.

19. Oct. 29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 25 1947, at 10 20 P M

21. I CERTIFY that death occurred on the date above stated; ~~that I last attended deceased from~~
Post mortem Examination 19...
and that I last saw deceased on Oct. 25, 1947

Immediate cause of death	DURATION
Fracture of skull	
Due to Stab wound with ice-pick in left side of neck	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of 10-25-47
Where did injury occur? Annapolis (City or town) A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?): at home
Means of injury: Blunt instrument + ice-pick Injured at work? no

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D.
Address: Annapolis Md Date signed 10/26/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

08741

21

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Brooklyn Heights — (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 18 yrs —

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Brooklyn Heights (If outside city or town limits, write RURAL and give nearest town)

Street No. 200 East Townsend Ave (If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME Louie M. Recker —

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married —

6.(b) Name of husband or wife: Edwin C. Recker

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): October 21, 1902

8. AGE:	Years	Months	Days	If less than one day
	45	—	1	...hrs. ...min.

9. Birthplace: Anne Arundel Co., Md. (Town, county, and state)

10. Usual occupation: Housewife —

11. Industry or business: At Home —

FATHER — 12. Name: George Adams

FATHER — 13. Birthplace: France —

MOTHER — 14. Maiden name: Mary Smith

MOTHER — 15. Birthplace: Maryland

16. Informant: Edwin C. Recker — (Husband)

Address: 200 E. Townsend Ave, Brooklyn, Md.

17. Buried (Burial, cremation, or removal? Which?) Date thereof: Sat, Oct. 25, 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cem —

Location: Anne Arundel Co., Md.

18. Funeral director: A. J. Townsend Evans

Address: 4005 S. Charles St, Balto 30, Md.

19. Oct 24 1947 (Date rec'd by registrar) A. W. Hellwig Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Wed, October 22, 1947, at 12:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 12 — 1947, to October 22 — 1947.

and that I last saw h.. alive on October 21 — 1947.

Immediate cause of death: Organic Heart Disease — DURATION: Unknown

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Chester Riland, M.D. M. D. or other

Address: 2532 Edmondson Ave Date signed: 10-23-47

to Baltimore Md.

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a BC 08742 21

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Anne Arundel
City or town Point Pleasant
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 or 3 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Balto
City or town Baltimore - 30
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1630 So. Charles St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Howard H. Reichenbach

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Laura Reichenbach
6.(c) If alive, give age Unknown years

7. Birth date of deceased (mo., day, yr.) September 10, 1885

8. AGE: Years 62 | Months 0 | Days 27 | If less than one day ..... hrs. ..... min.

9. Birthplace Liverpool Pa. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Carpentry
MOTHER FATHER 12. Name Daniel Reichenbach
13. Birthplace Liverpool, Pa.
MOTHER 14. Maiden name Mary Heyrold
15. Birthplace Liverpool Pa.
16. Informant Mrs Laura Reichenbach
Address Liverpool Pa.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 10, 1947 (month) (day) (year)
Cemetery or crematory Liverpool Cem.
Location Liverpool Pa.
18. Funeral director Thomas W. Dingletar
Address Glen Burnie Md.
19. 10/1 1947 L. J. Dodd Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1947 at about 2:30 A.M.
21. I CERTIFY that death occurred on the date above stated ~~and at the time and place and due to the cause~~
Post mortem Examination Oct. 7 1947
~~and that I last saw him alive on~~
Immediate cause of death Coronary Embolism — DURATION: Sudden
Coronary Sclerosis — DURATION: uncertain
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M Claffy M.D. Deputy Medical Examiner
M. D. or other
Address Annapolis Md. Date signed 10-7-47

OVER

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Permit given to
Palmer R. Garman
Mt Pleasant Mills
Penna.

Palmer R. Garman
Mt Pleasant Mills
Pa

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1600

08743

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Annapolis, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Louisiana County: St. Anthony Parish

City or town: New Orleans
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 412 S. Murat Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: RICHARD PATRICK RICKEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Infant

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 12 October 1947

8. AGE: Years	Months	Days	If less than one day
		3	..... hrs. ..... min.

9. Birthplace: Annapolis, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Richard Calvin Rickey
13. Birthplace: Lucasville, Ohio

MOTHER
14. Maiden name: Rose Francis Alice Otillar
15. Birthplace: New Orleans, La.

16. Informant: U. S. Naval Hospital,
Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 17th 1947 (month) (day) (year)

Cemetery or crematory: Naval Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor Son

Address: Annapolis, Md.

19. Oct. 16 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 October 1947 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Oct. 1947 to 15 Oct. 1947 and that I last saw h... im alive on 15 October 1947

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	3 days
Due to BIRTH INJURY	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: MULTIPLE CEREBRAL HEMOR.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G. M. Smith M.D. or other

Address: U.S. Naval Hospital, Annapolis, Md. Date signed 10/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, including exact age if especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 08744

CERTIFICATE OF DEATH

Reg. Dist. No. 23

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Linthicum Heights (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Charles & Mansion Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Anne Arundel
City or town: Linthicum Heights (If outside city or town limits, write RURAL and give nearest town)
Street No. Charles & Mansion Road (If rural, give LOCATION)
2(a) If veteran, name war: No

3. (a) FULL NAME Edith Jean Rogers
3. (b) Social Security Number 212-01-8048

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Mrg
6.(b) Name of husband or wife: Albert E Rogers
6.(c) If alive give age ... years
7. Birth date of deceased (mo., day, yr.): Feb 13 1887
8. AGE: Years 60 Months 7 Days 27 If less than one day ... hrs. ... min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Balto Ass'n Credit Men
FATHER 12. Name: Joseph C H Jean
13. Birthplace: Baltimore Md
MOTHER 14. Maiden name: Mary Rinkler
15. Birthplace: Baltimore Md
16. Informant: Mrs W H Garrett
Address: Linthicum Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/13/47 (month) (day) (year)
Cemetery or crematory: London Park
Location: Baltimore Md
18. Funeral director: William Cook Inc
Address: 1217 H Ford
19. 10/11 1947 A.W. Hedrick (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10 1947, at 2:55 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1946, to - 1947
and that I last saw her alive on ... 1947

	DURATION
Immediate cause of death: ACUTE CARDIAC FAILURE	
Due to: ARTERIOSCLEROTIC HEART DISEASE	
Due to: AND ASTHMATIC BRONCHITIS CHRONIC.	
Other conditions (Include pregnancy within 3 months of death)	

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE H J Zangaro M. D. or other
Address: Glen Burnie Date signed 10/10/47

VS A15 9-45 15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 08745

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

128 Market St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 128 Market

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary A. Russell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6th 1869

8. AGE: Years	Months	Days	If less than one day
77	11	14	hrs. min.

9. Birthplace Annapolis Md.

(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Charles H. Russell

13. Birthplace Dover Del.

MOTHER 14. Maiden name Tempa B. Mitchell

15. Birthplace Annapolis Md.

16. Informant Mrs. Milnor Meeking

Address Annapolis, Md.

17. Burial Date thereof 10/23/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Anne's Cemetery

Location Annapolis Md.

18. Funeral director John M. Taylor, Son

Address Annapolis Md.

19. Oct. 21 1947 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20. 1947, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947 to Oct 20 1947 and that I last saw h.e.r. alive on Oct 20 1947

Immediate cause of death	DURATION
Myocarditis + Myocardial Insufficiency	4 mos
Due to Arteriosclerosis	4 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. A. Bogel M. D. or other

Address Annapolis Md Date signed 10. 21. 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

164c 08747

Reg. Dist. No.

1. PLACE OF DEATH:
County Anne Arundel
City or town Dorsey
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, institution, or street address where death occurred: Forest Ave & Dorsey Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A. A.
City or town Dorsey
(If outside city or town limits, write RURAL and give nearest town)
Street No. Forest Ave. & Dorsey Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Walter George Seibert
3. (b) Social Security Number 705-12-1258

4. Sex: M.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Widowed.
6.(b) Name of husband or wife: Edna R. Hamilton Seibert
6.(c) If alive, give age: Dead. years
7. Birth date of deceased (mo., day, yr.): March-22-1895
8. AGE: Years 52 Months 6 Days 20 If less than one day ... hrs. ... min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: B.O. Transportation Clerk.
11. Industry or business
FATHER 12. Name: Henry Seibert
13. Birthplace: Germany, Europe.
MOTHER 14. Maiden name: Barbara ?
15. Birthplace: Germany
16. Informant: Mrs. Laurence Lusk (daughter)
Address: Dorsey, Md.
17. Cremation (Burial, cremation, or removal, Which?) Date thereof 10/15/47 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.
19. Oct 14 1947 (Date rec'd by registrar) A. W. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1947, at 8 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...
and that I last saw h... alive on ...19...

Immediate cause of death: Laceration of brain, Cerebral Hemorrhage Traumatic. –
Due to: Discharge of a revolver, caliber 32 - through
Other conditions: right temporal region.
(Include pregnancy within 3 months of death)
DURATION

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 10/12/47
Where did injury occur? Dorsey (City or town) A. A. (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Revolver - Caliber 32 Injured at work? No

23. SIGNATURE Gustave H. Fauber, M.D. Acting Medical Examiner
M.D. or other
Address 5-First Ave S.E. Glen Burnie Md. Date signed 10/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08746

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH: A. A. Co.

County A. A. Co.

City or town Jessup

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A. Co.

City or town Jessup

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles F. Sellner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of husband or wife Rose C. (Dersch) Sellner

6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) May 22nd 1889.

8. AGE:

Years	Months	Days	If less than one day
58	5	9	..... hrs. ..... min.

8. Birthplace Arlington, Va.

(Town, county, and state)

10. Usual occupation Guard - Honor Convict

11. Industry or business Penal Institution - State of Md.

FATHER

12. Name Joseph Sellner

13. Birthplace Austria

MOTHER

14. Maiden name Anna Frank

15. Birthplace Austria

16. Informant John M. Sellner

Address Jessup, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/3/47. (month) (day) (year)

Cemetery or crematory Meadow Ridge

Location near Dorsey, Md.

18. Funeral director Wm. J. Zickuhr & Sons

Address Baltimore, Md.

19. Nov 3 (Date rec'd by registrar) 19 47 Clara Hasler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31st 19 47 at 1205 noon. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1st 19 47 to Oct. 21st 19 47 and that I last saw him alive on Oct. 31st 19 47

Immediate cause of death	DURATION
Myocardial Degeneration	1 yr.
Due to Coronary Thrombosis	3 yr.
Due to	
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Shipley M.D.

M.D. or other

Address Savage, Md. Date signed 11/1/47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a 08749 22

CERTIFICATE OF DEATH

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne arundel
City or town: Jessups.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 days.
Hospital, institution, or street address where death occurred: Maryland Home for Consumptives
How long in hospital or institution? one half hour.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1001 - N. Bond St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Herbert Smith.

3.(b) Social Security Number:

4. Sex: M.
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married.
6.(b) Name of husband or wife: Julia Smith.
6.(c) If alive, give age: ... years
7. Birth date of deceased (mo., day, yr.): Sept 9. 1911
8. AGE: Years: 36 Months: 1 Days: 22 If less than one day: ... hrs. ... min.
9. Birthplace: Norfolk Va (Town, county, and state)
10. Usual occupation: Laborer -
11. Industry or business: —
FATHER 12. Name: Unknown
FATHER 13. Birthplace: "
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: "
16. Informant: M.T.C.
Address: Jessup Md.
17. (Burial, cremation, or removal. Which?) Burial Date thereof: Nov 7-47 (month) (day) (year)
Cemetery or crematory: Cherry Hill
Location: Jessup Md
18. Funeral director: W. L. Coellens
Address: Jessup Md
19. (Date rec'd by registrar) Nov 6 19 47 Registrar: Clara Harlup

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 21st 19 47, at 4.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Coronary Occlusion.	1 hr.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: NO Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Gustave A. Rauber M.D. (M. D. or other medical examiner)
Address: Glen Burnie Date signed: 10/21/47


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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08748

181

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 15 hours
Hospital, Institution, or street address where death occurred:
Annapolis Emergency Hospital
How long in hospital or institution? about 95 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Arnold
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Jones Station
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Katherine Somerville

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	negro	—

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 8, 1943

8. AGE: Years: 4 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Elijah Somerville
13. Birthplace: Arnold, A. A. County, Md.

MOTHER
14. Maiden name: Frances Kay
15. Birthplace: Arnold Md.

16. Informant: Elijah Somerville
Address: Jones Station, Arnold, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 7 1947 (month) (day) (year)
Cemetery or crematory: Carpenter's Hill
Location: Jones, Md.

18. Funeral director: Emil A. Johnson
Address: annapolis

19. Oct. 6, 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 5, 1947, at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated: Postmortem Examination Oct. 5, 1947

Immediate cause of death	DURATION
First and second degree	
Due to burns of almost the	
Due to whole body	15 hours
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Oct 4, 1947
Where did injury occur? Arnold (City or town) A. A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?): at home
Means of injury: was playing with matches Injured at work? no

23. SIGNATURE: John M. Claffy M.D., Deputy Medical Examiner
M. D. or other
Address: Annapolis, Maryland Date signed: Oct. 5 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08750

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 years.
Hospital, institution or street address where death occurred: Oakwood Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County A. A.
City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
Street No. Oakwood Road.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME ANTON - STANEK

3. (b) Social Security Number No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married.

6.(b) Name of husband or wife ANNA KELLNER
6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) April 21st 1871

8. AGE: Years	Months	Days	If less than one day
76	5	14	hrs. min.

9. Birthplace Austria-Hungary - Europe.
(Town, county, and state)
10. Usual occupation Sheet Metal Work
11. Industry or business
FATHER 12. Name ANTON - STANEK
13. Birthplace Austria Hungary, Europe.
MOTHER 14. Maiden name Mary ?
15. Birthplace Austria Hungary, Europe
16. Informant Mrs. A. Stanek (wife)
Address Glen Burnie, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 7 1947 (month) (day) (year)
Cemetery or crematory Glen Haven
Location Glen Burnie, Md
18. Funeral director Thomas W Singleton
Address Glen Burnie, Md.
19. 10/7 1947 (Date rec'd by registrar) L. J. O'Neill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5th 1947, at 4 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1944, to 10/4 1947
and that I last saw him alive on 10/4/47 1947
Immediate cause of death Coronary Occlusion — DURATION 2 hrs.
Due to Mitral Insufficiency — 3 yrs.
Due to Arteriosclerosis — ?
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide N/A Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gustave H Fauber M.D.
5 Fifth Ave S.E. M. D. or other
Address Glen Burnie Md. Date signed 10/5/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

402

08751

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 14 West Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Beattie L. Steiner

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George A. Steiner

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 8th 1882

8. AGE:

Years	Months	Days	If less than one day
65	8	0	hrs. min.

9. Birthplace: Danville, Illinois (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: Richard Taylor

13. Birthplace: Illinois

MOTHER

14. Maiden name: Mary E. McCarthy

15. Birthplace: Illinois

16. Informant: George A. Steiner

Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 10th 1947 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor, Inc.

Address: Annapolis, Md.

19. Oct 10 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 8 1947, at 3:50 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to Oct 8 1947 and that I last saw h alive on Oct 7 1947

Immediate cause of death	DURATION
Carcinoma of Rectum with metastasis to Liver &	7 yrs.
Due to: Gloma	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George C. Boyd M. D. or other

Address: Annapolis Md. Date signed: Oct. 8. 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

518 08753

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis, aryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, Institution, or street address where death occurred:
Emergency Hospital, Annapolis, Md.
How long in hospital or institution? 7 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 139 Charles St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
GEORGE HENRY STERLING

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Eva J. Sterling
6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): October 16, 1866

8. AGE: Years	Months	Days	If less than one day
81	0	8	hrs. min.

8. Birthplace ~~Ghrie~~ / Crisfield, Maryland
(Town, county, and state)

10. Usual occupation: Ret.
11. Industry or business

FATHER
12. Name: Shedrick Sterling
13. Birthplace: Maryland

MOTHER
14. Maiden name: SALLIE D. WILSON
15. Birthplace: MARYLAND

16. Informant: Miss Jeannette P. Sterling
Address: 139 Charles St. Annapolis, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-25-47 (month) (day) (year)
Cemetery or crematory: Cedar Bluff Cemetery
Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping and Son
Address: 170-172 West St. Annapolis, Maryland

19. Oct 25 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 24 1947 at 5:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 6 1947 to Oct. 24 1947 and that I last saw h...m alive on Oct. 24 1947.

Immediate cause of death	DURATION
Carcinoma of Prostate	
Due to Metastasis to Pelvis and Femurs	
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. Linthurst. M. D. or other
Address: Evergreen Rd Date signed 10/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

08752

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Chesterfield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Chesterfield

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Richard Luther Stevens

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary E. Stevens

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 4th 1872

8. AGE:

Years	Months	Days	If less than one day
75	4	11	..... hrs. ..... min.

9. Birthplace: Calvert Co. Md.

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: Samuel Stevens

13. Birthplace: Calvert Co. Md.

MOTHER

14. Maiden name: Margaret Turner

15. Birthplace: Calvert Co. Md.

16. Informant: Mary E. Stevens

Address: Chesterfield, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/19/47 (month) (day) (year)

Cemetery or crematory: Edwards Chapel

Location: Parole, Md.

18. Funeral director: John M. Taylor, Son

Address: Annapolis, Md.

19. Oct 17 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 15, 1947, at 10 45 P. M.

21. I CERTIFY that death occurred on the date above stated; [redacted] Post mortem 1947 Examination Oct. 16, 1947 [redacted]

	DURATION
Immediate cause of death: Acute Dilatation of Heart	Sudden
Due to: Arterio-sclerosis	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner

M. D. or other

Address: Annapolis, Maryland Date signed 10-16-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

137 08754 M

Reg. Diat. No.

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Millersville
(If outside city or town limits, write RURAL and give nearest town)
How long in abeve place of death? 16 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? 16 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Millersville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Struzzykawski

3.(b) Social Security Number: 215-09-3345

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Catherine Struzzykawski
6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): aug 6 1898

8. AGE:

Years	Months	Days	If less than one day
49			....hrs. ....min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: Longshoreman
11. Industry or business

FATHER
12. Name: Anthony Struzzykawski
13. Birthplace: Poland

MOTHER
14. Maiden name: Pauline Jadurszky
15. Birthplace: Poland

16. Informant: Mrs. Catherine Struzzykawski
Address: P.O. Millersville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 4 1947 (month) (day) (year)
Cemetery or crematory: Holy Rosary Cem
Location: Baltimore County
18. Funeral director: John M. Weber
Address: 401 S. Chester Street
19. Oct 2 1947 (Date rec'd by registrar) A. W. Hebert Registrar
28

MEDICAL CERTIFICATION 15

20. DATE OF DEATH: Oct 1 1947 at 4 M

21. I CERTIFY that death occurred on the date abeve stated; that I attended deceased from Aug 15 1947 to Oct 1 1947
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
EMACIATION	
Due to TUBERCULOSIS - DIFFUSE BILATERAL PULMONARY	
Due to —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Henry Zangara M.D.
M. D. or other
Address: Glen Burnie Md. Date signed 10/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95C

09503

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Pines on the Severn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Arnold
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Pines on the Severn
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Amelia Archer Turner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Leonidas T. Turner
6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): March 14, 1869

8. AGE:

Years	Months	Days	If less than one day
78	7	22	hrs. min.

9. Birthplace: Belair, Harford Co., Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER
12. Name: Roland D. Archer
13. Birthplace: Belair, Maryland
MOTHER
14. Maiden name: Emma Hunter
15. Birthplace: Belair, Md.
16. Informant: Robert D. Turner
Address: 4426 - 7th St. N.W. Wash D.C.
17. Buried (Burial, cremation, or removal. Which?) Date thereof Nov 7 1947 (month) (day) (year)
Cemetery or crematory: Lorraine Pk
Location: Woodlawn Md.
18. Funeral director: Henry A Wetzel
Address: 4101 Elmondson Ave
19. 11-7 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 5 1947, at 1.00 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem Examination 19..
~~and that I last saw h... alive on~~ Oct. 5, 1947

Immediate cause of death	DURATION
Acute Dilatation of Heart	sudden
Due to: Hypertension & arterio-sclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John McCaffy, M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed 11-5-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08755

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A. A. Co.

City or town Annapolis Emergency Hospl.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.

City or town Rural Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. White Hall Beach

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harry W. Ullmann

3.(b) Social Security Number

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Elizabeth C. Ullmann

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 17th 1895

8. AGE: Years 62 | Months 1 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace Great Neck Long Island (Town, county, and state)

10. Usual occupation Ret. Insurance

11. Industry or business Insurance

FATHER 12. Name Henry Ullmann

13. Birthplace Germany

MOTHER 14. Maiden name Rosamunde Diem

15. Birthplace Germany

16. Informant Edgar A Ullmann

Address Martha Long Island

17. Burial Removal (Burial, cremation, or removal. Which?) Date thereof Oct 14th 1947 (month) (day) (year)

Cemetery or crematory

Location New York City

18. Funeral director John M. Taylor Son

Address Annapolis Maryland

19. Oct. 14 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1947, at 2 20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1941 to Oct 11 1947 and that I last saw h. alive on Oct 11 1947

	DURATION
Immediate cause of death: Coronary occlusion	36 hrs.
Due to: arteriosclerotic cardiovascular disease	15 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Bruce M D

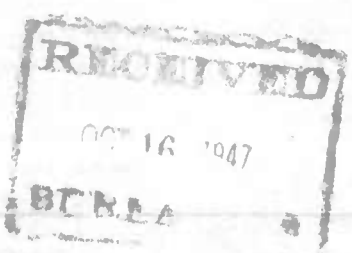
M. D. or other

Address Annapolis Md Date signed Oct 13 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
OCT 16 1947
BCRLA

Evidence for the change of year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

08756

Reg. Dist. No. 21

File No. G 113 NOV 24 1947

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Davidsonville, Maryland P.O.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MATHIAS WAGNER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Theresia Anna Wagner

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): September 15, ~~1877~~ 1877

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
70	1	7		

9. Birthplace: Hungary (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

MOTHER FATHER

12. Name: John ~~Wagner~~ Wagner

13. Birthplace: Mr. Temesvar, Hungary.

14. Maiden name: Margarite Kuhn

15. Birthplace: Mr. Temesvar, Hungary.

16. Informant: Mr. Michael P. Wagner (Son)

Address: Davidsonville, P.O., Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-25-47 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Md.

19. Oct. 25 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22, 1947 at 9.30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 20, 1947 to October 22 1947 and that I last saw h... alive on October 22, 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to: Arteriosclerotic Cardio-Vascular Disease	2 yr.
Due to:	
Other conditions: Cardiac Dilatation	2 days

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert R. Anderson M.D. M. D. or other

Address: Annapolis, Md. Date signed: 10/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

08757

2411 N. Charles St., Baltimore 87e

CERTIFICATE OF DEATH

Reg. Diat. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: ANNE ARUNDEL

City or town: RURAL - LAUREL, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4½ years +

Hospital, institution, or street address where death occurred:

District Training School - Laurel, Md

How long in hospital or institution? 4½ years +

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: ANNE ARUNDEL

City or town: RURAL - ~~LAUREL~~ LAUREL

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME: THOMAS WASHINGTON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	S

6.(b) Name of husband or wife —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): JAN. 14. '32

8. AGE: Years 15 | Months 8 | Days 24 | If less than one day: ... hrs. ... min.

9. Birthplace: Wash., D.C. (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name: GEORGE

FATHER 13. Birthplace: Md.

MOTHER 14. Maiden name: GUSSIE

MOTHER 15. Birthplace: Md.

18. Informant: History - D.C. TRAINING School

Address: LAUREL, Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 10 - 10 - 47 (month) (day) (year)

Cemetery or crematory —

Location: Washington DC.

18. Funeral director: Barnes & Matthews

Address: 614 - 4" St. S.W. Wash. 4. D.C.

19. Oct 10 19 47 (Date rec'd by registrar) Clara Washington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 - 8 19 47, at 5⁰⁵ A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-26 19 43 to 10-8- 19 47

and that I last saw h. l. M. alive on 10-7-47 19 ...

	DURATION
Immediate cause of death: Epilepsy	birth
Due to: birth injury with spastic quadriplegia	birth
Due to:	
Other conditions: mental deficiency - idiot	birth

(Include pregnancy within 3 months of death)

Major findings of operation —

Date of op. ...

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: James Ewald M.D. M. D. or other

Address: District School, Laurel, Md. Date signed: 10/8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08758

186a

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Harwood
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lucy Pindell Welch

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 25th 1866

8. AGE: Years	Months	Days	If less than one day
81	7	10	hrs. min.

9. Birthplace: A. A. Co. Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: B. Allen Welch
13. Birthplace: West River - A.A.Co. - Md.

MOTHER
14. Maiden name: Leacinda Pindell
15. Birthplace: West River - A.A.Co. - Md.

16. Informant: Gertrude A. Welch
Address: Harwood - A.A.Co. - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 10th 1947 (month) (day) (year)

Cemetery or crematory: Christ Church Cemetery

Location

18. Funeral director: John M. Taylor - Son

Address: Annapolis Md

19. Oct. 10, 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7 1947, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 22 1947 to Oct 7. 1947

and that I last saw h.. liv..ative on 19

Immediate cause of death: Coronary occlusion.

Due to: thrombosis.

Due to: fracture neck of femur -

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings at operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of

Where did injury occur? Harwood, A.A. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Slipped & fell. Injured at work? 11/22/47 a.s.

23. SIGNATURE: Emily H. Wilson M. D. or other

Address: Lothian Md. Date signed 10/9/47.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

08759

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: King George Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: U.S.N. Experiment Station

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: George Samuel Wilson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 29th 1931

8. AGE: Years: 16 | Months: 4 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Annapolis, A. A. Co. - Md. (Town, county, and state)

10. Usual occupation: Student at Annapolis High School

11. Industry or business

12. FATHER — Name: George S. L. Wilson

13. FATHER — Birthplace: Annapolis, Md.

14. MOTHER — Maiden name: Bernice Hall

15. MOTHER — Birthplace: Calvert Co. Md.

16. Informant: Mrs. Geo. S. L. Wilson

Address: U.S.N. Experiment Station

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 16th '47 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis Md.

18. Funeral director: John M. Taylor Son

Address: Annapolis

19. Oct. 16 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 13 1947 at 7:21 P. M.

21. I CERTIFY that death occurred on the date above stated: Post mortem Examination Oct. 13 1947

	DURATION
Immediate cause of death: Compound Fracture of Skull	
Compound Fracture of Rt. thigh	
Due to: Compound Fracture of left Ulna and	
Compound Fracture left thigh	
Due to: and lower leg	
Amputation of left Leg	
Other conditions: Injury.	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 10-13-47

Where did injury occur? Annapolis (City or town) A. A. (County) Maryland (State)

Injured at home, farm, industry, public place (where?): King George St

Means of injury: Auto-motor scooter collision Injured at work? No

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner

M. D. or other

Address: Annapolis, Md. Date signed: 10-15-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92 L

08760

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne arundel

City or town: Waterbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs

Hospital, institution, or street address where death occurred:

above Crownsville, P.O.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Crownsville, P.O.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Agnes Wtzik

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White8	Widowed

6.(b) Name of husband or wife: Joseph

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 1, ~~1947~~ 1876

8. AGE: Years	Months	Days	If less than one day
71	9	22	..... hrs. ..... min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Joseph Rosemark

13. Birthplace: Poland

MOTHER

14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: Mr. Stanley Sowinski

Address: 4701 N. Point Rd Dundalk, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-27-47 (month) (day) (year)

Cemetery or crematory: St Mary's Cemetery

Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Maryland

19. Oct 25, 1947 E. Joyce Love (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 23 1947, at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 20, 1947 to Oct. 28 1947 and that I last saw her alive on Oct. 23 1947

Immediate cause of death	DURATION
Chronic Endocarditis	2 years
Due to Mitral Insufficiency	2 yrs
Due to and decompensation	1 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John M. Claffy M.D. M. D. or other

Address: Annapolis, Md. Date signed 10-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

08761

Reg. Dist. No. 21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort Smallwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Fort Smallwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5-1

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary E. Windsor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John N. Windsor

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 16th 1861

8. AGE:

Years	Months	Days	If less than one day
86	5	4	..... hrs. ..... min.

9. Birthplace: Churchton, A. A. Co., Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: John E. Howe

13. Birthplace: A. A. Co. Md.

MOTHER

14. Maiden name: Sarah F. Randall

15. Birthplace: A. A. Co. Md.

16. Informant: Mrs. Thomas J. Cummings

Address: Fort Smallwood - A. A. Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/22/47 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis Md.

18. Funeral director: John M. Taylor

Address: Annapolis, Md.

19. Oct. 21 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 20 1947, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1940, to Oct 20 1947 and that I last saw h.. alive on Oct 19 1947

Immediate cause of death	DURATION
Myocarditis chr	7 yrs
Due to Arteriosclerosis	unknown
Due to	
Other conditions Secondary Anemia	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Geneva C Boyd M. D. or other

Address: Annapolis Md Date signed 10-21-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

08762

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Greenland Beach, Curtis Bay P.O (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Greenland Beach (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Lee Wright

3.(b) Social Security Number:

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife:
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): May 2. 1946

8. AGE: Years 1 Months 5 Days 24 If less than one day ... hrs. ... min.

9. Birthplace: Denton, Maryland (Town, county, and state)
10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Thomas F. Wright
13. Birthplace: Wilmington - Del

MOTHER
14. Maiden name: Elizabeth Ann Hubbard
15. Birthplace: Greensboro. Md

16. Informant: Thomas F. Wright
Address: Greenland Beach. Curtis Bay P.O. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 28, 1947 (month) (day) (year)
Cemetery or crematory: Denton, Maryland
Location: Denton, Md

18. Funeral director: J. Virgil Moore & Son
Address: Denton, Maryland

19. 10-28 19 47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 26 1947, at 12 10 P. M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~
Postmortem Examination 19
~~...~~ 19

Immediate cause of death: Drowning

Due to:

Due to:

Other conditions: (Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 10-26-47
Where did injury occur? Greenland Beach A.A. Maryland (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Weldon Creek
Means of injury: fell off pier Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner (M. D. or other)
Address: Annapolis, Md Date signed: 10-26-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

08763

Reg. Dist. No. 22

1. PLACE OF DEATH:

County A. G.

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County

City or town Charlestown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 207 East Liberty St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Stanley Merle Writt.

3. (b) Social Security Number 232-10-7454

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13 - 1897

8. AGE: Years	Months	Days	If less than one day
49	9	25	hrs. min.

9. Birthplace W. Virginia (Town, county, and state)

10. Usual occupation Crakes and counter. Mfg.

11. Industry or business

FATHER 12. Name C. O. Writt

13. Birthplace Virginia

MOTHER 14. Maiden name Mary A. Clift

15. Birthplace W. Va.

16. Informant C. O. Writt

Address Charlestown, W. Va.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 10-9-47 (month) (day) (year)

Cemetery or crematory Edge Hill

Location Charlestown W. Va.

18. Funeral director Midcap Striker Co.

Address Charlestown, W. Va.

19. Oct 10-8 (Date rec'd by registrar) 1947 Clara Kasluh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1947 at 7.50 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 to 19

and that I last saw h alive on — 19

Immediate cause of death	DURATION
Coronary occlusion	sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gustave H. Faucheux M.D. M. D. or other

Address Glen Burnie, Md Date signed 10/8/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING